THIS AGREEMENT DATED the 9th day of September, 2016

BETWEEN:

HER MAJESTY THE QUEEN in the right of the Province of Nova Scotia, as represented by the Minister of Health and Wellness (hereinafter called the "Minister")

OF THE FIRST PART

- and -

DOCTORS NOVA SCOTIA, as represented by the President and Chair, Board of Directors (hereinafter called "DNS")

OF THE SECOND PART

- and -

NOVA SCOTIA HEALTH AUTHORITY and/or the **IWK HEALTH CENTRE**, as represented by the Chief Executive Officer(s) (hereinafter called the "Health Authority")

OF THE THIRD PART

- and -

DALHOUSIE UNIVERSITY, on behalf of the Faculty of Medicine (hereinafter called the "University")

OF THE FOURTH PART

- and -

DR. GODFREY HEATHCOTE, Head of Department of Pathology at the Faculty of Medicine at Dalhousie University and Chief of the Department of Pathology at the Health Authority and IWK and Chair of the Committee of C/AFP Department Heads, on behalf of the Committee (hereinafter called the "CC/AFPDH")

OF THE FIFTH PART

PREAMBLE

WHEREAS the DHW has the power, pursuant to the *Health Services and Insurance Act,* 1989, R.S.N.S., c.197, as amended to negotiate in good faith compensation for insured medical services with professional organizations representing providers and may establish fees or other systems of payment for insured medical services and, with the approval of the Governor-in-Council, may authorize payment in respect thereof;

AND WHEREAS pursuant to the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, Doctors Nova Scotia is recognized as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia;

AND WHEREAS C/AFP Physicians are members of the C/AFP Departments as well as the Faculty of Medicine for the University and in such dual capacity carry out a combination of integrated clinical, teaching, research and administrative activities for which a system of payment other than fee for service is appropriate.

AND WHEREAS the Parties acknowledge that a primary purpose of this Agreement is to facilitate the provision of an integrated delivery of clinical care, education, research and ancillary administrative services by the Departments;

WITNESSETH that the Parties hereto agree as follows:

1.0 DEFINITIONS

1.1 "C/AFP" means Clinical Academic Funding Plan.

1.2 "C/AFP Physician(s)" means Full-time C/AFP Physician(s) and Part-time C/AFP Physician(s).

1.3 "CC/AFPDH" means the Committee of C/AFP Department Heads.

1.4 "Agreement" means this Agreement dated the 9th day of September, 2016.

1.5 "Annual Funding" means funding from the Minister, the Health Authorities, and the University directly to a Department as set out in the Schedules for each Department as attached hereto.

1.6 "Billing Number(s)" means the billing number(s) and/or business arrangement(s) assigned to a physician pursuant to the Medical Services Insurance Plan for Department activities.

1.7 "Clinical Services Reporting" means the reported billings of a C/AFP Physician of insured services encounter information to MSI in the form prescribed by the Department of Health and Wellness.

1.8 "Day(s)" means calendar day(s).

1.9 "Deliverables" means those Deliverables set out in the Schedules.

1.10 "Department" means all C/AFP departments and includes divisions of current non-C/AFP academic departments.

1.11 "Department Head" means the individual or individuals appointed Chief of a Department at the Health Authority and Head of a Department in the Faculty of Medicine at the University, or anyone authorized to act in the stead of this individual(s). For the purposes of this Agreement, Department Head includes an individual appointed Chief of a Division that is a C/AFP Division within a non-C/AFP Department.

1.12 "Department Practice Plan" means the internal arrangement agreed to by the C/AFP Physicians with respect to the roles and responsibilities of the C/AFP Physicians, and which includes the mechanism for determining the responsibilities and payment mechanism of the C/AFP Physicians within the C/AFP Department.

1.13 "DHW" means the Nova Scotia Department of Health and Wellness.

1.14 "Effective Date" means April 1, 2015.

1.15 "Expiry Date" means March 31, 2019.

1.16 "Faculty of Medicine" means the Faculty of Medicine at the University.

1.17 "Full-time C/AFP Physician" means a medical practitioner who is qualified and Royal College of Physicians and Surgeons of Canada or College of Family Physicians Canada certified or equivalent to practice medicine (listed in the applicable register of the College of Physicians and Surgeons of Nova Scotia), and has the necessary training to carry out his or her assigned Department activities and who is a member of a Department at the Health Authority and who holds an academic appointment with a Department in the Faculty of Medicine at the University.

1.18 "Health Authority" means the Nova Scotia Health Authority or the IWK Health Centre, as appropriate.

1.19 "Master Agreement" means the agreement between DNS and the Minister dated as at September 9, 2016 and as amended from time to time, attached hereto as Appendix 5, and any successor agreements during the term of this Agreement.

1.20 "Minister" means the Minister of the Department of Health and Wellness.

1.21 "MSI Plan" means the Medical Services Insurance Plan administered by or on behalf of the Minister for payment to C/AFP Physicians for providing insured professional services pursuant to this Agreement.

1.22 "MSU" means Medical Service Unit as defined in the Master Agreement.

1.23 "Part-time C/AFP Physician" means a medical practitioner who is fully qualified

and Royal College of Physicians and Surgeons of Canada or College of Family Physicians Canada certified or equivalent to practice medicine (listed in the applicable register of the College of Physicians and Surgeons of Nova Scotia), and has the necessary training required to carry out his or her assigned Department activities and who is a member of a Department at the Health Authority and who holds an academic appointment with a Department in the Faculty of Medicine at the University and whose work with a C/AFP Department is less than that of a 1.0 FTE.

1.24 "Reciprocal Billing" means billings received by the Province of Nova Scotia from extra-Provincial sources for medical services rendered by a C/AFP Physician, such services having been provided to residents of other Provinces, excluding the Province of Quebec.

1.25 "Year" means April 1st of one calendar year to March 31st of the next calendar year.

2.0 RESPONSIBILITIES OF THE PARTIES

2.1 It is the mutual intent of the Parties that this Agreement benefit all the Parties while enhancing patient care and advancing education and research in an integrated setting and, accordingly, each Party will act in good faith and make all reasonable efforts to achieve those ends. In order to achieve the goal of providing quality healthcare, all of the Parties acknowledge the need to recruit and retain well-qualified healthcare providers.

2.2 Pursuant to section 7 of the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, and other applicable authority, DHW recognizes DNS as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia who provide Insured Medical Services that are funded through DHW and/or a Health Authority.

2.3 The Parties agree to negotiate in good faith and make every reasonable effort to conclude a subsequent agreement prior to the expiry of this Agreement.

2.4 The Parties agree to utilize and support the AFP Model, including its governance structure and committees.

3.0 DELIVERABLES

3.1 The Minister, the Health Authority, and the University each agree to provide their portion of the Annual Funding in accordance with this Agreement and the Schedules and the Department and the C/AFP Physicians agree to provide the Deliverables as outlined in the appropriate Schedule and overseen by the appropriate Department Head.

4.0 OUT OF PROVINCE BILLING

4.1 The Department shall make all reasonable efforts to ensure that 100% of all out of

province billings ("OPB") is completed and submitted for payment to the Department of Health and Wellness. The C/AFP Physicians' OPB shall be audited by MSI on an annual basis to ensure compliance with DHW rules governing OPB and will assist with any audit that DHW undertakes. In the event that the audit reveals actual OPB of less than 95% of the OPB which the Minister considers to be eligible OPB, the Minister shall recover such unbilled amounts from monies otherwise payable to the Department pursuant to this Agreement. OPB applies to clinical services rendered by a C/AFP to a person who is not a resident of Nova Scotia where such services were provided within the province of Nova Scotia.

5.0 PAYMENT FOR SERVICES RENDERED

5.1 The Parties agree that unless specifically provided for in this Agreement, and as agreed upon by the Parties in the development of Provincial programs, no C/AFP Physician shall be paid by fee for service billing for services provided in the C/AFP environment unless agreed by DHW, the Health Authority, and the Department Head.

5.2 Except as otherwise provided, the Parties agree that:

(i) all Full-time C/AFP Physicians; and
(ii) all Part-time C/AFP Physicians while providing services in accordance with the Deliverables,

shall be paid exclusively from the Annual Funding established in accordance with this Agreement.

5.3 Notwithstanding Article 5.2, the Parties agree that C/AFP Physicians are permitted to receive payment for services provided for and fees received from work outside of the Deliverables, so long as for 1.0 FTE or greater C/AFP Physicians such services are agreed upon in advance by the Minister, the Health Authority, the University, and the Department Head.

5.4 The Department Heads will be responsible for tracking the services of a 1.0 FTE or greater C/AFP Physician referred to in Article 5.3, and will provide a report on a quarterly basis to the Minister, the Health Authorities, and the University.

5.5 The Parties agree that any non-C/AFP physician may only provide services in the C/AFP environment if such services are provided with approval of the Health Authority and such services must be provided through the C/AFP.

5.6 For greater clarity, this Article 5 does not restrict C/AFP Physicians from receiving payment from third parties for services provided, as long as the services provided are above and beyond the C/AFP Physician's responsibilities to the Department as determined by the Department Head and are not counted toward the Department's deliverables or Clinical Services Reporting. Third parties includes but is not limited to the Workers' Compensation Board, medico-legal claims, uninsured billings, Province of Quebec billings, out-of-country billings, honorarium and contract research.

5.7 The Annual Funding established under this Agreement is inclusive of all On-call Services outlined in each Department's Deliverables and all Full-time C/AFP Physicians and all Part-time C/AFP Physicians who are providing services in a C/AFP environment are required to perform On-call Services in accordance with their Department Practice Plan and the direction of their Department Head.

6.0 ANNUAL FUNDING

6.1 Subject to the terms of this Agreement, commencing on the Effective Date and terminating on the Expiry Date, the Departments shall annually receive funding in the amounts set out in the individual Schedules, as adjusted from time to time such as (1) by agreed changes in the Department FTE complement; (2) by agreed changes to the Minister's funding to the Department; or (3) by increase in Department funding via Targeted Funding outlined in Article 6.3 (collectively, the "Block Funding").

6.1.1 The following annual increases will apply to the Minister's portion of the Block Funding (Including targeted funding added in prior years in accordance with Article 6.3) effective April 1 of each year of this Agreement:

Fiscal Year	Rate Increases
April 1, 2015 – March 31, 2016	0%
April 1, 2016 – March 31, 2017	0%
April 1, 2017 – March 31, 2018	0.5%
April 1, 2018 – March 31, 2019	1.5%

6.2 Payment of the Annual Funding shall be made to the Departments as follows:

6.2.1 The Minister's portion of the Block Funding will be transferred bi-weekly to the Department. The Department Head will hold back 10% of each transfer (the Holdback). A review of the Department Deliverables scorecard (see Appendix 2) will be completed by DHW, Dalhousie and the Health Authority on a quarterly basis to ensure Deliverables are generally being met. The Department will be free to release the Holdback in accordance with its practice plan no later than ninety (90) days after submission of all Deliverables Reports. This Article is effective April 1, 2017.

6.2.2 The University's portion of the Block Funding will be paid to the Department from a University operating account and will be subject to University regulations, policies, procedures and guidelines relating to such accounts.

6.2.3 The Health Authority's portion of the Block Funding will be paid to the

Department from the Health Authority's operating account and will be subject to Health Authority regulations, policies, procedures and guidelines relating to such accounts.

6.3 The Minister will also provide targeted funding, to be paid by the Minister to the Departments in the proportions recommended by the CC/AFPDH as follows ("Targeted Funding"):

Fiscal Year	Amount
April 1, 2015 – March 31, 2016	0%
April 1, 2016 – March 31, 2017	$1,000,000
April 1, 2017 – March 31, 2018	$2,000,000 plus the additional 0.5% annual increase as referred to in Article 6.4
April 1, 2018 – March 31, 2019	$2,000,000

6.4 In addition, an amount equal to a 0.5% annual increase will be available for fiscal 2017/18.

6.5 The Minister will provide the current, global level of the administrative support budget to the Health Authorities.

6.6 The Health Authorities agree that any portion of the budget referred to in Article 6.5 which is not expended shall be returned to the Minister.

7.0 SPACE AND SUPPORT

7.1 The Health Authority will continue to provide for the Departments during the life of this Agreement all space and support being utilized by the Departments at the time of entering into this Agreement and as subsequently agreed to between the Health Authority and the Department (collectively, the "Space and Supports"). Should the Health Authority decide that changes to any of the Space and Supports are required, these changes shall be discussed with the appropriate Department Head in advance. This shall include the impacts on the Department's ability to meet its Deliverables and any resulting changes to the Deliverables shall be made. If agreement with respect to changes to the Deliverables is not reached, any Party may submit the matter to the C/AFP IRC as applicable for review and recommendation to the C/AFPMG. Normal operating cost increases associated with Space and Supports (including remuneration increases arising through agreement negotiations for other health and support staff) will be absorbed by the Health Authority.

7.2 The University will continue to provide for the Departments during the life of this Agreement all space and support being utilized by the Departments at the time of entering into this Agreement and as subsequently agreed to between the University and the

Department (collectively, the "Space and Supports"). Should the University decide that changes to any of the Space and Supports are required, these changes will be discussed with the appropriate Department Head in advance where practicable, and in all circumstances Department Heads will be notified of changes. The Department Head will notify the University of any potential impacts on the Department's ability to meet its Deliverables and any resulting changes to the Deliverables that may be necessary. If agreement with respect to changes to the Deliverables is not reached, any Party may submit the matter to the C/AFP IRC as applicable for review and recommendation to the C/AFPMG. The University will be responsible for annual salary adjustments (relating to the portion of salary that is not recoverable) arising through University negotiated agreements and related processes for University support staff (unionized and Dalhousie Professional Managerial Group).

8.0 FUNDING CONTRIBUTIONS

8.1 In addition to the Annual Funding, the Minister agrees, in accordance with Article 4.1(e) of the Master Agreement and any relevant article of any subsequent agreement between DNS and the Minister annually, to provide the Canadian Medical Protective Association rebate.

9.0 RELATIONSHIP OF DEPARTMENT HEAD AND C/AFP PHYSICIANS TO THE HEALTH AUTHORITY AND THE UNIVERSITY

9.1 It is acknowledged by the Parties and all C/AFP Physicians who participate under this Agreement that the activities, responsibilities, and accountabilities as outlined in this Agreement do not constitute all of the activities or responsibilities of the C/AFP Physicians.

9.2 The Parties acknowledge that from time to time the Departments may include members who are not C/AFP Physicians but who hold academic appointments at the University and Affiliated Scientist privileges with the Health Authority. Such Department members work together with the C/AFP Physicians in achieving the Deliverables.

9.3 The Parties acknowledge that the Department Heads and each C/AFP Physician has additional responsibilities in accordance with the by-laws, rules and regulations of the Health Authority and the Health Authority Medical Staff By-laws and with the regulations, policies, procedures, and guidelines of the University and the Faculty of Medicine.

9.4 The Parties agree that nothing in this Agreement, including the description of the Deliverables in the Schedules, is intended to restrict or limit the existing authority of the Department Heads, including the authority to agree with the Health Authority or the University regarding those services or activities not expressly described in the Deliverables which are required to meet the health care delivery, research and education mandate of the Health Authority or the academic, education and research mandate of the University and to assign these services and activities to the C/AFP Physicians. Further, upon the agreement of a Department Head, in accordance with the

authority granted pursuant to their Department Practice Plan, such agreement shall bind all C/AFP Physicians in that Department.

10.0 DEPARTMENT PRACTICE PLAN

10.1 The Department Practice Plans shall be developed and implemented by the Departments with approval of the requisite number of members of the Department as determined by the Department for purposes of substantive decision-making. Approval of this Agreement, and any amendments thereto, shall be in the manner agreed to by the C/AFP Physicians in their Department Practice Plan. The Department Practice Plans may be reviewed by the Minister, the Health Authorities, and the University so that the Minister, the Health Authorities, and the University are satisfied that the Department Practice Plans do not conflict with any rules, regulations, or by-laws of any of the foregoing.

10.2 The Department Practice Plans shall be consistent with the Practice Plan Principles approved by the C/AFP Governing Board, appended hereto as Appendix 3.

11.0 C/AFP COMPLEMENT

11.1 The Department Heads will be responsible for putting processes in place to promote alignment with the physician resource plan of the Minister and the Health Authorities, as it evolves to reflect an 80/20 clinical/other ratio.

11.2 The Departments will maintain their current complement, as set out in the Schedules. A Department's complement will only be altered in the following circumstances:

11.2.1 Workload Fluctuations: If there is an increase or decrease in workload for a Department, the Department Head will meet with DHW, a representative of the appropriate Health Authority, and a representative of the University to determine a solution.

11.2.2 Vacancies: If the number of C/AFP Physicians in a Department is going to be or is reduced as the result of a permanent departure, the parties agree that the Department will fill the vacancy unless the Health Authority determines otherwise. The applicable Department Head will provide written notice to DHW when the Department Head becomes aware that a vacancy will occur. Funding for the position will be available unless and until a decision is made not to fill the vacancy within that Department. The CC/AFPDH will meet to discuss whether to recommend filling the vacancy within the current Department, or filling a vacancy in another Department. A representative of the CC/AFPDH, as determined by the CC/AFPDH will meet with a representative of the appropriate Health Authority to discuss the vacancy. The Health Authority will

then make a recommendation to the New MD Committee as to whether to fill the vacancy as recommended by the CC/AFPDH or to fill another vacancy outside the C/AFP Departments.

11.2.2.1 If a replacement is approved by the New MD Committee, funding for the vacancy will continue to be transferred until the replacement begins work or for a period of one (1) year from the date the vacancy commenced, whichever is earliest, so long as the Department can demonstrate need for the funding to cover replacement clinical work. Department Heads may seek an extension of the vacancy funding period upon written request to the New MD Committee, such request to be received no fewer than thirty (30) days before the expiry of the period.

11.2.2.2 If a replacement is not approved by the New MD Committee, representatives of the Minister, the Health Authority, and the University will meet with the Department Head to determine if an adjustment to deliverables is necessary.

11.3 Over the period of this Agreement, the Department of Health and Wellness will provide $2,800,000 to the New MD Committee (or its equivalent) for recruitment of new physicians on a provincial basis, including C/AFP, fee for service and alternative payment plan physicians, as follows:

Fiscal Year	Amount
April 1, 2015 – March 31, 2016	0%
April 1, 2016 – March 31, 2017	$600,000
April 1, 2017 – March 31, 2018	$1,600,000
April 1, 2018 – March 31, 2019	$600,000

11.4 If a Department Head retires from the role of Department Head and this does not result in a vacancy for that Department, the Department may, with the approval of the New MD Committee, obtain temporary funding referred to as "Dean's pool funding", to allow for the addition of a Department Head from outside the Department. The funding will be used to support the position until a vacancy occurs within the Department, at which time the Dean's pool funding to that Department will cease.

12.0 NO CLAIMS AGAINST INSURED PROFESSIONAL SERVICES AND OTHER UNDERTAKINGS

12.1 Each C/AFP Physician by signing the Declarations attached hereto as Appendices 1A and 1B agrees to be bound by the terms and conditions of this Agreement. The

Declaration shall be signed within twenty (20) days of the signing of this Agreement. Until all C/AFP Physicians in a Department sign this Declaration, the Agreement shall not come into effect for that Department. As a result of signing the Declarations the C/AFP Physician undertakes to comply with the terms of this Agreement, the Practice Plan of their Department, and the rules and regulations and by-laws of all Parties. Further, unless specifically provided for in this Agreement, the C/AFP Physician agrees that they will not claim or accept payment either directly or indirectly for any clinical services rendered in accordance with the terms and conditions of this Agreement until the expiry of this Agreement, except as provided herein.

12.2 The Parties agree that all Billing Numbers presently held by Full-time C/AFP Physicians will be suspended for the term of this Agreement, including any extension of this Agreement, but will be reinstated immediately upon the termination or expiry of this Agreement unless otherwise agreed by all Parties. Notwithstanding the foregoing, if a physician ceases to be a Full-time C/AFP Physician, as defined herein, her or his Billing Number will be restored without affecting the suspension noted above for the remaining C/AFP Physicians. Part-time C/AFP physicians practicing in a C/AFP shall not be permitted to bill MSI for work performed in the C/AFP.

12.3 If a Department or Full-time C/AFP Physician accepts any payment from MSI except as provided by in accordance with this Agreement, the Minister may deduct the same amount from any monies otherwise owing to the Department under this Agreement.

12.4 Payments received under OPB pursuant to Article 4 shall be treated in the same manner as Article 12.

13.0 REPORTING

13.1 By each of June 30, September 30, December 31, and March 31 of each year of this Agreement the Department shall provide DHW and the University with the Department Deliverables scorecard (attached as Appendix 2).

13.2 By June 30 of each year commencing June 30, 2017 the Departments shall provide DHW and the University with a completed Deliverables Template as set out in the Department's Schedule, a Vacancy Report, a Complement Report, the Department Practice Plan (if revised from the previous year) and if produced, the Department Annual Report (collectively, the "Deliverables Reports"). By June 30 of each year commencing June 30, 2017 the Departments shall also provide DHW with a completed Disbursement Report. An Audited Financial Statement for the Minister's funding, which must include an Income Statement, shall be provided to DHW as soon as practicable following the Department's fiscal year end.

13.3 In the event that a Department Head fails to deliver the reports provided for in Articles 13.1 or 13.2 within the time provided for the delivery of such reports, the Minister may withhold one or more of the bi-weekly payments pending delivery of such report.

14.0 INSPECTION

14.1 DHW, during the term of this Agreement and for three (3) years thereafter, upon reasonable notice to a Department, may inspect all financial records and other materials related to the operation, administration of this Agreement to:

14.1.1 Verify the information set out in the reports delivered in compliance with this Agreement; and

14.1.2 Verify the amounts provided by the Minister.

15.0 AMENDMENT OF AGREEMENT

15.1 This Agreement may be amended upon written approval by all of the Parties.

16.0 TERM AND TERMINATION

16.1 The term of this Agreement will be four (4) years, commencing on the Effective Date and ending on the Expiry Date.

16.2 Only the annual adjustment of Minister's funding referred to in Article 6.1.1 of this Agreement will take effect on the Effective Date; all other elements of this Agreement will take effect on signing.

16.3 Notwithstanding Article 16.1 this Agreement may be terminated by any Party by giving twelve (12) months' notice of termination to the other Parties. No such notice shall be effective until the commencement of the DHW fiscal year that follows the completion of the twelve (12) months' notice given.

16.4 Any Department may terminate that Department's Schedule and remove the Department from this Agreement by giving notice to all Parties as outlined in Article 16.3.

16.5 The Parties agree that no division within a Department may withdraw from this Agreement without the written consent of all Parties.

16.6 The Parties agree that they will, upon request, negotiate C/AFPs with any non-C/AFP academic Departments.

17.0 INDEPENDENT CONTRACTOR

17.1 It is understood and agreed that this Agreement is for the performance of services and that, except in relation to any salary paid to the C/AFP Physicians by the University, the C/AFP Physicians are engaged as independent contractors and are not nor shall be deemed to be employees, servants or agents of the Minister. For further

clarity, it is understood by all Parties to this Agreement that each C/AFP Physician:

17.1.1 shall be free to engage and dismiss support staff at their own expense subject to any appropriate collective agreement, with the exception of staff support from the Health Authority or the University funding or on the Health Authority or University payroll;

17.1.2 shall exercise his or her own judgment in offering medical advice and treatment;

17.1.3 shall be required to arrange his or her own liability insurance;

17.1.4 shall be free to offer his or her services to others for remuneration in accordance with Article 5;

17.1.5 shall be free to arrange his or her own hours subject to their Department Practice Plan; and

17.1.6 shall not be entitled to employee benefits paid by the Province including but not limited to health and dental, life insurance, paid sick leave, long term disability coverage, paid vacation leave, participation in the Public Service Superannuation Fund or paid statutory holidays or paid parental leave.

17.2 As independent contractors the C/AFP Physicians shall be solely responsible for remittance of all payments for Income Tax and like obligations as are or may be required from the C/AFP Physicians according to law, in respect of the services rendered by the C/AFP Physicians or by anyone employed by the C/AFP Physicians. The C/AFP Physicians shall indemnify the Parties for any liability which may occur due to the C/AFP Physicians' failure to make remittances as it relates to anyone employed by the C/AFP Physicians.

18.0 WORK INTERRUPTION

18.1 The Parties agree that no Department will be liable for its failure to perform any of its obligations under this agreement due to a catastrophic cause beyond its control including, but not limited to acts of God, fire, flood, explosion, strikes, lock outs or other industrial disturbances. As soon as practicable after such work interruption, the Parties will meet to discuss how to best mitigate the impact of the work interruption.

19.0 ASSIGNMENT

19.1 This Agreement shall not be assigned by any Party for any reason without the prior written consent of the other Parties. Notwithstanding the foregoing, the Minister's funding may be directed to an organization or corporation of the C/AFP Physicians to facilitate the business management of a Department Practice Plan with the written consent of the Minister.

20.0 NOTICE

20.1 All notices under this Agreement shall be deemed duly given upon being delivered by hand, or three days after being posted or sent by registered mail, receipt requested, to a Party at the address set out in the Schedules or to such other addresses designated by a Party.

21.0 ENTIRE AGREEMENT

21.1 This Agreement, the Appendices and the Schedules attached hereto or referred to herein constitute the whole Agreement between the Parties concerning the subject matter herein unless duly modified in writing and signed by all Parties. No representation or statement not expressly contained herein shall be binding upon any Party.

22.0 GOVERNING LAWS

22.1 This Agreement shall be construed and interpreted in accordance with the laws of the Province of Nova Scotia. This Agreement shall enure to the benefit of and is binding upon the Parties hereto and their respective successors and assigns.

23.0 PARTIAL INVALIDITY

23.1 If any term or provision of this Agreement shall be found to be illegal or unenforceable, it will be deemed to be severed from this Agreement and the remaining provisions will nevertheless continue to be in full force and effect.

24.0 LIABILITY

24.1 The Minister shall not be liable for any injury or damage (including death) to the person or for loss or damage to the properties of other persons in any manner based upon, occasioned by or in any way attributable to the other Parties' services under this Agreement unless such injury, loss or damages caused solely and directly by the negligence of an officer or servant of the Minister while acting within the scope of this Agreement.

25.0 PRIOR AGREEMENTS

25.1 This Agreement supersedes all the agreements between the Parties executed before the Effective Date.

IN WITNESS WHEREOF the Parties hereto have executed this agreement on the day and year first above written.

SIGNED, SEALED AND DELIVERED
in the presence of:

HER MAJESTY THE QUEEN in right of the Province of Nova Scotia, as represented by the Minister of Health and Wellness

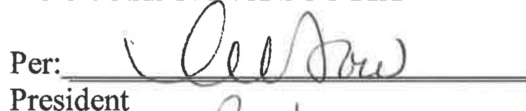
Witness

Per: ____________________

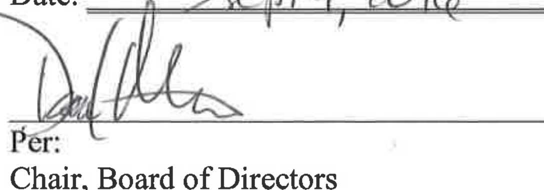
Date: Sept 8, 2016

DOCTORS NOVA SCOTIA

Witness

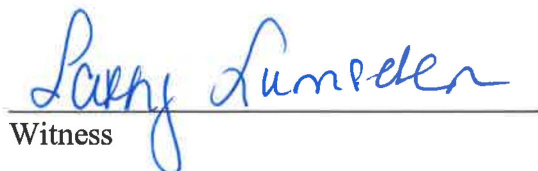

Per: ____________________
President
Date: Sept 9, 2016

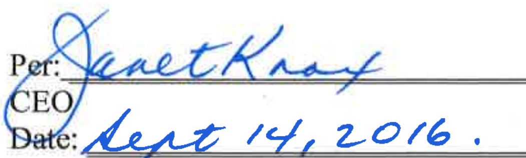
Witness


Per:
Chair, Board of Directors

Sept 9/16
Date

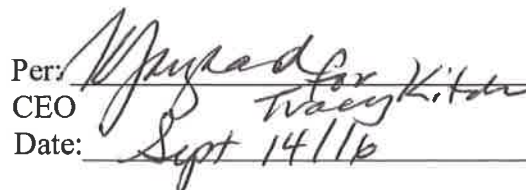
NOVA SCOTIA HEALTH AUTHORITY


Witness


Per: ____________________
CEO
Date: Sept 14, 2016.

IWK HEALTH CENTRE

Witness


Per: ____________________
CEO
Date: Sept 14/16

	)	**DALHOUSIE UNIVERSITY**
	)	
	)	Per: C. Watters
Witness K. Gallivan	)	C. WATTERS PROVOST + VP ACADEMIC
		Date: Sept 14/16
		Per:
Witness K. Gallivan	)	Ian C. Nason Vice-President Finance and Administration Dalhousie University
		Date: Sept 14/16
	)	**DR. GODFREY HEATHCOTE,** in his capacity as Chair, Committee of Clinical/Academic Funding Plan Department Heads
	)	
	)	Per: J. G. Heathcote
Witness	)	
	)	Date: Sept. 09 /2016

SCHEDULE LISTING

Schedule A – Department of Anesthesia, Pain Management, and Perioperative Medicine

Schedule B – Department of Critical Care

Schedule C – Department of Emergency Medicine

Schedule D – Department of Family Medicine

Schedule E – Division of Gynecologic Oncology

Schedule F – Department of IWK Diagnostic Imaging

Schedule G – Department of Medicine

Schedule H – Department of Pathology and Laboratory Medicine

Schedule I – Department of Pediatrics

Schedule J – Department of Psychiatry

Schedule K – Department of Radiation Oncology

Schedule L – Department of Surgery

Schedules removed

Available from C/AFP Department Heads

APPENDIX 1A

FULL-TIME DECLARATION

CLINICAL/ACADEMIC FUNDING PLAN FULL-TIME PHYSICIAN DECLARATION

TO: MINISTER OF HEALTH AND WELLNESS
PROVINCE OF NOVA SCOTIA

TO: CEO
NOVA SCOTIA HEALTH AUTHORITY

TO: CEO
IWK HEALTH CENTRE

TO: DEAN
DALHOUSIE UNIVERSITY, SCHOOL OF MEDICINE

TO: PRESIDENT
DOCTORS NOVA SCOTIA

TO: CHAIR, COMMITTEE OF CLINICAL/ACADEMIC FUNDING PLAN DEPARTMENTS HEADS

I,____, hereby declare to you as follows:

1. THAT I am a Full-time C/AFP Physician and remunerated by a Department for my professional activities as a member of the Department, effective ______________________

2. THAT my remuneration from the Department includes remuneration, out of funds provided by the Minister, for my rendering medical services to insured persons. Subject to the terms and conditions of the agreement which has been entered into between the Minister of Health and Wellness, the Chair of the CC/AFPDH, Dalhousie University, the NSHA, the IWK, and Doctors Nova Scotia dated as of September 9, 2016 (the "Agreement"), I accept this remuneration in lieu of any payment that I might otherwise be entitled to claim for and receive from MSI in respect of services rendered by me as a C/AFP Physician.

3. THAT, subject to the terms and conditions of the Agreement, I will not claim for or accept payment from MSI with respect to services provided pursuant to the Agreement, either directly or through a group for any insured services that I render on and after __________, 2016 as a Full-time C/AFP Physician, until the expiration or termination of the agreement.

4. THAT I acknowledge receipt of a copy of the Agreement and agree to be bound by the provisions of the Agreement, including, but not limited to, the requirement to fulfill my role in provision of the Deliverables as may be required pursuant to the terms and conditions of the Agreement and those roles which may be specifically assigned by the Department Head or his delegate from time to time.

5. THAT I specifically agree to comply with provisions with respect to Clinical Services Reporting as it is required pursuant to the terms of the Agreement.

6. THAT I understand that I am an independent contractor and I agree that I am solely responsible for the remittance of all payments for Income Tax, all income source deductions, contributions and like obligations as are or may be required by me, the appropriate Health Authority, Doctors Nova Scotia, the Department Head or the Minister of Health and Wellness according to law, in respect of the services rendered by me or anyone employed by me under the Agreement. I agree to indemnify and hold harmless Doctors Nova Scotia, the University, Her Majesty the Queen, the Minister of Health and Wellness, and the appropriate Health Authority for any and all claims and liability including, but not limited to, any fines, penalties or legal costs incurred in defending any such claims which may occur as a result of any failure to make such remittances.

7. THAT I agree to abide by the Health Authority By-laws and Medical Staff By-laws for the appropriate Health Authority, rules and regulations made pursuant to such By-laws, the applicable policies of the appropriate Health Authority, and the Practice Plan of my Department.

8. That I acknowledge that the Department Head acts solely and exclusively as a delegate of the appropriate Health Authority and the University in the scope of performing the oversight of the Department and that his or her primary responsibility and duty in that capacity is to the appropriate Health Authority and the University.

All capitalized terms used in this Declaration and not defined herein shall have the meanings ascribed to them in the Agreement.

DATED at Halifax, Nova Scotia, this day of , 201___.

Signature of
Physician: ____ __________

APPENDIX 1B

PART-TIME DECLARATION

CLINICAL/ACADEMIC FUNDING PLAN PART-TIME PHYSICIAN DECLARATION

TO: MINISTER OF HEALTH AND WELLNESS
PROVINCE OF NOVA SCOTIA

TO: CEO
NOVA SCOTIA HEALTH AUTHORITY

TO: CEO
IWK HEALTH CENTRE

TO: DEAN
DALHOUSIE UNIVERSITY, SCHOOL OF MEDICINE

TO: PRESIDENT
DOCTORS NOVA SCOTIA

TO: CHAIR, COMMITTEE OF CLINICAL/ACADEMIC FUNDING PLAN DEPARTMENTS HEADS

I,____, hereby declare to you as follows:

1. THAT I am a Part-time C/AFP Physician and remunerated by a Department for my professional activities as a member of the Department, effective ____________________

2. THAT my remuneration from the Department includes remuneration, out of funds provided by the Minister, for my rendering medical services to insured persons. Subject to the terms and conditions of the agreement which has been entered into between the Minister of Health and Wellness, the Chair of the CC/AFPDH, Dalhousie University, the NSHA, the IWK, and Doctors Nova Scotia dated as of September 9, 2016 (the "Agreement"), I accept this remuneration in lieu of any payment that I might otherwise be entitled to claim for and receive from MSI in respect of services rendered by me as a C/AFP Physician.

3. THAT, subject to the terms and conditions of the Agreement, I will not claim for or accept payment from MSI with respect to services provided pursuant to the Agreement, either directly or through a group for any insured services that I render on and after __________, 2016 as a Part-time C/AFP Physician, until the expiration or termination of the agreement.

4. THAT I acknowledge receipt of a copy of the Agreement and agree to be bound by the provisions of the Agreement, including, but not limited to, the requirement to fulfill my role in provision of the Deliverables as may be required pursuant to the terms and conditions of the Agreement and those roles which may be specifically assigned by the Department Head or his delegate from time to time.

5. THAT I specifically agree to comply with provisions with respect to Clinical Services Reporting as it is required pursuant to the terms of the Agreement.

6. THAT I understand that I am an independent contractor and I agree that I am solely responsible for the remittance of all payments for Income Tax, all income source deductions, contributions and like obligations as are or may be required by me, the appropriate Health Authority, Doctors Nova Scotia, the Department Head or the Minister of Health and Wellness according to law, in respect of the services rendered by me or anyone employed by me under the Agreement. I agree to indemnify and hold harmless Doctors Nova Scotia, the University, Her Majesty the Queen, the Minister of Health and Wellness, and the appropriate Health Authority for any and all claims and liability including, but not limited to, any fines, penalties or legal costs incurred in defending any such claims which may occur as a result of any failure to make such remittances.

7. THAT I agree to abide by the Health Authority By-laws and Medical Staff By-laws for the appropriate Health Authority, rules and regulations made pursuant to such By-laws, the applicable policies of the appropriate Health Authority, and the Practice Plan of my Department.

8. That I acknowledge that the Department Head acts solely and exclusively as a delegate of the appropriate Health Authority and the University in the scope of performing the oversight of the Department and that his or her primary responsibility and duty in that capacity is to the appropriate Health Authority and the University.

All capitalized terms used in this Declaration and not defined herein shall have the meanings ascribed to them in the Agreement.

DATED at Halifax, Nova Scotia, this day of , 201___.

Signature of
Physician: ______________________________ __________

APPENDIX 2

DEPARTMENT DELIVERABLES SCORECARD

Encompasses DHW, Health Authorities and Dalhousie

The Quarterly Scorecard is designed to provide DHW, NSHA, IWK and Dalhousie with a general outline of whether key deliverables are being achieved. It is not designed to be a substitute for the year-end reporting requirements, which will be the basis on which final payments to AFP department are being made. Moreover, failure to meet requirements in the Quarterly Scorecard generally will not result in a holdback of AFP funds.

DHW

Quarterly submission of the following from the C/AFP Department to DHW:

1. Quarterly Complement Report based on FTEs in the AFP Department, including departures during the quarter
2. Vacancy Report

NSHA / IWK

Indicate Yes or No. If no, provide an explanation.

1. Department provided 24/7 continuous on-call services for both emergency and inpatient care Y_____ N______
2. All Medical Administrative positions as outlined in the Deliverables Template have been filled Y_____ N______
3. Department participated in quality and patient safety initiatives and reviews for NSHA/IWK as outlined in the Deliverables Template Y_____ N______
4. Department has a quality framework that aligns with the quality and patient safety framework of the NSHA/IWK Y_____ N______
5. Departmental / divisional leaders have worked with the NSHA/IWK in a co-leadership model, as outlined in the Deliverables Template Y_____ N______
6. Department is on track to maintain a comparable level of patient care activities as was provided in the previous fiscal year (unless adjusted by agreement)

   Y_____ N______
7. Department will provide leadership and participation into health system change as outlined in the Deliverables template Y_____ N______

Dalhousie

Indicate Yes or No. If no, provide an explanation.

Undergraduate Medical Education teaching has been performed satisfactorily, as per Faculty of Medicine annual request and in accordance with accreditation requirements Y_____ N______

DHW Reporting to C/AFP Departments

DHW shall provide to each department the shadow billing report for the Department, as compiled by Medavie Blue Cross.

APPENDIX 3

PRACTICE PLAN PRINCIPLES

AFP Practice Plan Principles
October 20, 2011

1. The Clinical Academic Department will structure its Practice Plan in accordance with the principles of:
    a. Accountability
    b. Fairness
    c. Transparency
    d. Integrity
    e. Stewardship
2. The Practice Plan policies and processes will allow the Department to support the mandates of the Department, Health Authority, IWK, University, and Department of Health and Wellness through the AFP deliverables and AFP Guiding Principles and will be approved by all Partners.
3. The Practice Plan will be flexible and responsive to allow the Department to reallocate and recruit resources over the life of the AFP to meet changing demands.
4. The Practice Plan, through the Practice Profile, will be structured to optimize each member's professional strengths for the benefit of the individual, the relevant division and the department as a whole.
5. The Practice Plan will enable the Department to maintain an adequate divisional / departmental human resource complement that is aligned with and responsive to the needs of the Department, District, IWK, University, and Department of Health and Wellness.
6. The full scope of all professional activities of each Department member (i.e. clinical, teaching, research, leadership and administration) will be valued equitably by the Practice Plan.
7. The Practice Plan will require each member to have a practice profile that includes:
    a. A position description;
    b. A set of clearly defined and measureable deliverables aligned with the overall Departmental deliverables;
    c. An annual remuneration; and,
    d. The process for annual performance evaluation;
8. Remuneration policies within a Practice Plan will:
    a. Be based upon fair national market values for each subspecialty;
    b. Outline how academic rank and clinical / research seniority will be valued;

c. Outline how individual member remuneration will be impacted if not meeting deliverables as outlined in the practice profile; and,

d. Reward excellence and innovation in all professional activities (i.e. clinical, teaching, research and administration).

9. The Practice Plan will include a dispute resolution mechanism and explain in detail how and when it is applied.

10. The Department's Practice Plan will be financially responsible, accountable, and transparent to its funding partners and members.

11. The Practice Plan will partner with the Health District, University, and DHW to support the core academic (teaching and research) activities of the department.

12. It is accepted that Departments may have reasons for not introducing particular elements required by the above principles. In that case, an explanation of the omission must be included in the Practice Plan document.

APPENDIX 4

AFP DEFINITIONS

Post-AFPMG approval, July 2014

Definitions adhere to the AFP Guiding Principles
Note: Time cannot be claimed more than once, and must be categorized as a single activity. For example, clinical care with a learner present must be claimed as "Clinical Care" or "Clinical Teaching".

Clinical

CLINICAL CARE

Essential Elements:

1. Clinical Care is care delivered when a patient(s) is named/identifiable, recognizing that the patient does not need to be in front of the Physician for care to be delivered (for example, Lab Medicine or DI).
2. A key component of the definition is that it is a professional activity delivered by a physician to serve the clinical needs of a specific, identifiable patient or group of patients (This includes any named, identifiable patient. If the efforts are to address clinical care within a certain service or area of the hospital it also qualifies because supporting the delivery of care for that specific group is the focus of the activity).
3. Activity related to the provision of care for the benefit of a patient or groups of patients. This can be both direct care to the patient and related activities and processes that arise from this care or support this care, both for an individual and for the patient population served by the clinician.
4. Bedside clinical care, whether it is billable under MSI or any other route, must be captured and that the provision of care with or without learners is relevant.
5. Direct supervision/collaboration of allied health provider by an MD.
6. The provision of a standard of care in the course of research is "clinical care". Any care delivered incremental to the standard of care is "clinical research".

Examples:

1. Face to face patient care/indirect care (typing, billing)
2. Any direct patient care (clinics, OR's, ward rounds, home visits, etc)
3. Investigation of patient problem by literature review, consulting colleagues, etc
4. Travel to home visits, alternate care sites (EXCLUDING time for a clinician to travel from his/her home to their USUAL place of work)
5. Time spent on call giving active patient care (in person, by phone advice to other clinicians, trainees & patients/families)

6. Patient-related Family Meetings
7. Discussions (in person, on phone, or electronic) related to patient care with other clinicians (physician & non-physician), patients or family members
8. Any clinical medicine related to these activities (review of lab/radiology results, phone calls/forms/letters on behalf of patients, review of or completion of medical records)
9. Care planning (case conferences, multidisciplinary discussions, etc)

CLINICAL TEACHING

Essential Elements:

1. Teaching or supervision of learners where clinical care* is being delivered.

Examples:

1. Bedside teaching.
2. Discussions or provision of guidance to learners directly or indirectly related to the patient being seen.
3. Procedural teaching or supervision in the context of clinical care.
4. Supervision in the OR.
5. Feedback on clinical performance.

CLINICAL RESEARCH

Essential Elements:

1. The objective of research is the creation of new knowledge (as opposed to an investigation of existing knowledge, for example, by performing a literature review for the treatment of a patient)
2. Clinical Research:
   a. Patient-oriented research conducted with human subjects (or on material of human origin such as tissues, specimens and cognitive phenomena) for which an investigator (or colleague) directly interacts with human subjects. Excluded from this definition are in vitro studies that utilize human tissues that cannot be linked to a living individual. Patient-oriented research may include: Mechanisms of human disease; Therapeutic interventions; Clinical trials; Development of new technologies. [1]
   b. Epidemiologic and behavioral studies; [2]
   c. Outcomes research and Health services research. [3]
3. The provision of a standard of care in the course of research is "clinical care". Any care delivered incremental to the standard of care is "clinical research".

Examples:

***Please refer to Clinical Care definition**

[1] National Institutes of Health, Office of Public Health and Science (US), PHS 398 definitions, page III-25

[2] National Institutes of Health, Office of Public Health and Science (US), PHS 398 definitions, page III-25

[3] National Institutes of Health, Office of Public Health and Science (US), PHS 398 definitions, page III-25

1. Analysing data from clinical care databases (e.g. database tracking regional cancer patients protocols, etc.)
2. Translational research- transforms scientific discoveries from laboratory, clinical, or population studies into clinical applications to reduce disease incidence, morbidity, and mortality.
3. Publication of new concepts/techniques, invention of medical apparatus, description of illnesses or critical review of published work
4. Supervision/mentorship of research trainees
5. Preparing and submitting grant applications
6. Publication of the results of original research and investigation.
7. Literature Review required for a research project
8. Research data acquisition and analysis
9. Designing and conducting research protocols including, but not limited to, recruitment and enrolment, data collection, research interventions that are beyond the standard of care.

CLINICAL ADMINISTRATION

Essential Elements:

1. Clinical Administration enhances the care to patients through public health, organization improvements, etc.
2. Clinical Administration activities are necessary to support delivery of care to a patient population.

Examples:

1. Policy development intended to advance models of clinical care.
2. Improving clinic flow
3. Sitting on a National directed care committee (e.g. National Advisory Committee on Immunization)
4. Designing new hospital or clinic facilities
5. Regional coordination of care for population groups
6. Work directed towards developing or maintaining a local or regional clinical program (i.e. Regional Hem/Onc Program – with central coordination of all care to all children in the Maritimes and supervision/direction to regional sites)
7. Participation on Morbidity & Mortality(M&M) and QA committees
8. Maintenance of clinical care databases (e.g. database tracking, regional cancer patients, protocols, etc.)
9. Clinical program design and improvement
10. Care pathways development and implementation.
11. Clinical Co-Leadership activities
12. Physician HR activities such as recruitment and retention

Education

NON-CLINICAL TEACHING

Essential Elements:

1. Teaching or supervision of learners where no clinical care* is being delivered.

Examples:

1. Lectures and tutorials on clinical skills.
2. Simulations.
3. Providing formative and summative evaluations.
4. Clinical demonstrations using a patient for educational/training purposes and where no care is delivered.

EDUCATION ADMINISTRATION

Essential Elements:

1. Administrative activity that is related to the operational or organizational aspects of delivering any health- related educational program.
2. Curricular development, assessment design and the delivery of faculty development are education activities and not education administration.

Examples:

1. Scheduling rotations
2. Collecting student In-Training Evaluation Reports (ITERs)/, ITARs(In-Training Assessment Reports) from faculty members
3. Recruiting tutors/preceptors
4. Administering and coordinating examinations but not designing Objective Structured Clinical Exams (OSCEs) or developing Multiple Choice Questions (MCQs) for example which are educational activities
5. University accreditation activities
6. Committees or meetings related primarily to educational curriculum operations, logistics or organization
7. Resident recruiting interviews
8. Letter writing re: student references/evaluations

Research

BASIC SCIENCE RESEARCH

Essential Elements:

1. The objective of research is the creation of new knowledge.
2. Basic Science Research reflects knowledge creation directed toward the improvement of health but is not conducted on human subjects nor human tissue that can be linked to an individual.

Examples:
1. Publication of new concepts/techniques, invention of medical apparatus, description of illnesses or critical review of published work
2. Supervision/mentorship of research trainees
3. Presentation at professional and scientific meetings or conferences;
4. Preparing and submitting grant applications
5. Publication of the results of original research and investigation
6. Literature Review required for a research project
7. Research Data Acquisition/Analysis
8. Research Protocols

EDUCATION RESEARCH

Essential Elements:
1. The objective of research is the creation of new knowledge.
2. Education Research reflects knowledge creation where the subject of the research is the curriculum, the prospective learner/ current learner/ graduate and/or the learning process.

Examples of Research On:
1. New clerkship models
2. New residency models
3. Simulation
4. Learning and teaching methods
5. Publication of new concepts/techniques or critical review of published work
6. Supervision/mentorship of research trainees
7. Presentation at professional and scientific meetings or conferences;
8. Preparing and submitting grant applications
9. Publication of the results of original research and investigation
10. Literature Review required for a research project
11. Research data acquisition\analysis
12. Designing and conducting research protocols including, but not limited to, recruitment and enrolment, data collection, research interventions that are beyond the standard of care
13. Selection and Admission criteria
14. Career choice research

RESEARCH ADMINISTRATION

Essential Elements:

1. The objective of research is the creation of new knowledge.
2. Any administrative activity that is related to the operational or organizational aspects of any health-related research program.

Examples:
1. Maintenance of clinical care databases
2. Participating on Research Review Panels and Research Ethics Board
3. Managing a research budget
4. Committee work or meetings related to research infrastructure, policy or funding not related to a specific research project.

Administration

GENERAL ADMINISTRATION

Essential Elements:
1. Administrative activity related to the governance, management or leadership of institutions, organizations, and/or the profession.
2. Administrative activity that does not relate to clinical care, research or education.

Examples:
1. Sitting on AFP Model committees
2. All budgeting and finance committees
3. Search and Survey Committee
4. Facility planning committees
5. Leadership position or participation in Regional, National and/or International societies. Note: Specific committees within these organizations may have a clinical, research, or education focus and therefore would be captured as clinical, education or research administration
6. Non-clinical Co-Leadership activities
7. Serving in executive or leadership roles in professional organizations, advancing the medical profession, such as the Royal College, CMA, DNS, CMPA. Note: Specific committees within these organizations may have a clinical, research, or education focus and therefore would be captured as clinical, education or research administration
8. Physician HR activities such as recruitment and retention
9. Hospital/University fundraising activities

APPENDIX 5

MASTER AGREEMENT

THIS AGREEMENT DATED the 9th day of September, 2016

PHYSICIAN SERVICES MASTER AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NOVA SCOTIA, as represented by the Minister of Health and Wellness ("**DHW**")

OF THE FIRST PART

-and-

DOCTORS NOVA SCOTIA, as represented by the President of Doctors Nova Scotia ("**DNS**")

OF THE SECOND PART

AGREEMENT PREAMBLE

WHEREAS DHW has the power, pursuant to the *Health Services and Insurance Act, 1989, R.S.N.S., c.197,* as amended, to negotiate in good faith compensation for Insured Medical Services with professional organizations representing providers and may establish fees or other systems of payment for Insured Medical Services and, with the approval of the Governor-in-Council, may authorize payment in respect thereof;

AND WHEREAS pursuant to the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, Doctors Nova Scotia is recognized as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia;

AND WHEREAS the Parties acknowledge that DHW has an obligation to maintain and improve the health status of the population, to determine service organization, and to determine the allocation of provincial funding for health services consistent with this Agreement;

AND WHEREAS the Parties agree that the Health Authorities are responsible for regional service planning and operations and allocation of fiscal, human and capital resources to meet the health service needs of Insured Residents;

AND WHEREAS the parties, together with the Health Authorities, wish to continue to work together in a relationship built upon transparency, constructive collaboration and mutual respect;

THEREFORE in consideration of the terms of this Physician Services Master Agreement (the "**Agreement**"), the Parties agree as follows:

1. DEFINITIONS

In this Agreement:

(a) **"2008 Master Agreement"** means the Physician Services Master Agreement executed by the Parties in October 2008, as amended;

(b) **"Act"** means the *Health Services and Insurance Act, 1989, R.S.N.S., c.197,* as amended;

(c) **"Agreement"** means this document including all Schedules as amended from time to time in accordance with this Agreement;

(d) **"Clinical Services Reporting"** means reporting by Physicians of Insured Medical Service encounter information to MSI in the format prescribed by DHW;

(e) **"Fee Committee"** means the Fee Committee as outlined in Article 4.1(d) of this Agreement;

(f) **"General Practitioner"** means a Physician registered with the College of Physicians and Surgeons whose name does not appear on the Medical Specialist Register, but includes those who have either a CCFP or CCFP-EM certification;

(g) **"Health Authorities"**, means the Nova Scotia Health Authority as defined in the *Health Authorities Act, S.N.S. 2014, c. 32*, and the IWK Health Centre;

(h) "**Insured Medical Services**" means insured medical services that Insured Residents are entitled to receive under the provisions of the Act and the regulations made pursuant thereto;

(i) "**Insured Residents**" are Residents of Nova Scotia as defined by the Act and the regulations made pursuant thereto;

(j) "**MAMG**" means the Master Agreement Management Group as outlined in Article 5 of this Agreement;

(k) "**MASG**" means the Master Agreement Steering Group pursuant to the 2008 Master Agreement;

(l) "**MSI**" means the Medical Services Insurance program, administered on behalf of the Province, for the payment to Physicians for providing Insured Medical Services pursuant to the Act;

(m) "**MSI Physician's Manual**" means the document that contains the Preamble and Insured Medical Services, including their descriptions and codes, any special conditions and their value in units;

(n) "**Physician**" means a medical practitioner under the *Medical Act, S.N.S. 1995-96, c. 10 as amended*, of Nova Scotia who is licensed by the College of Physicians and Surgeons of Nova Scotia to practice medicine in the Province, in good standing and not subject to any suspension of license;

(o) "**Preamble**" means the Preamble to the MSI Physician's Manual that provides the billing rules and is the authority for the proper interpretation of the Insured Medical Services;

(p) "**Resident Physician**" is a Physician registered with the College of Physicians and Surgeons in an educational category of the Medical Register and registered at a recognized university in Canada in a postgraduate course of study in medicine;

(q) "**Sessional Rate**" means the fee paid for eligible medical services of a Physician engaged on a time basis;

(r) "**Specialist**" means a Physician registered with the College of Physicians and Surgeons whose name appears on the Medical Specialist Register of Nova Scotia, excluding those who have either a CCFP or CCFP-EM certification;

(s) "**Tariff**" means the system of payment for Insured Medical Services as outlined in the MSI Physician's Manual and defined in the Act;

(t) "**Unit Value System**" means the representation of the actual fees for Insured Medical Services by separate unit categories: the Medical Service Unit (MSU) and the Anaesthesia Unit (AU);

(u) "**Year**" means the fiscal year of the Province of Nova Scotia, from April 1 to March 31.

2. TERM OF AGREEMENT

(a) This Agreement shall take effect on April 1, 2015 and continues to remain in force and effect for a period of four (4) years, terminating on March 31, 2019.

(b) Only the rate increases referred to in Article 4.1(b) of this Agreement will take effect on April 1, 2015; all other elements of this Agreement will take effect upon execution by both Parties.

(c) This Agreement and the attached Schedules constitute the whole Agreement between the parties unless duly modified in writing and signed by both parties. No representation or statement not expressly contained herein will be binding upon any party.

(d) Upon termination of this Agreement, the Tariff then in effect on March 31, 2019 and the provisions of Articles 4.1 (e) and 4.1 (k) shall remain in effect until such time as the Parties agree upon a new Agreement, or a new Agreement is established. Further, for the purposes of this Agreement all other provisions shall continue after termination until such time as the Parties agree upon a new Agreement, or a new Agreement is established.

3. RESPONSIBILITIES OF THE PARTIES

(a) DNS recognizes that DHW oversees and directs funding for the health care system across the Province, within the limits of a budget that is a portion of provincial program spending allocated to DHW by the Nova Scotia Legislature and Department of Finance.

(b) DNS agrees to co-operate with the Health Authorities in facilitating the delivery of Insured Medical Services and will take all appropriate measures to encourage Physicians to comply with applicable agreements.

(c) Pursuant to section 7 of the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, and other applicable authority, DHW recognizes DNS as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia who provide Insured Medical Services that are funded through DHW and/or a Health Authority.

(d) DHW and DNS agree to negotiate in good faith and make every reasonable effort to conclude a subsequent agreement prior to the expiry of this Agreement.

4. PHYSICIAN COMPENSATION

4.1 General and Fees

(a) Unit Value System

(i) All costing, payments and statistical analysis will be based on "date of service" and more specifically, the Tariff in place on the date the Insured Medical Service is provided.

(ii) The portion of the Tariff, which includes the Preamble and the Insured Medical Services agreed to pursuant to the Act, will continue to be published with the actual fee represented in units and will be formalized in

regulations made pursuant to the Act, as necessary. The Tariff in effect as of April 1, 2015 shall remain in effect except to the extent altered by the terms of this Agreement.

(iii) The units will continue to be categorized as follows:

(A) Medical Service Units (the "MSU") for all Insured Medical Services except anaesthesia services; and

(B) Anaesthesia Units (the "AU") for all anaesthesia services.

(iv) The MSU value is currently 2.42 and the AU value is currently 20.55.

(b) Rate Increases

(i) The following annual increases will apply to the MSU, the AU, the Sessional hourly rates, the Intensive Care Unit ("ICU") minimum income daily guarantees, the Emergency Department ("ED") hourly rates, the Psychiatry hourly rates, the CAPP rates (including the mentor and ED assessment rates), the Collaborative Emergency Centre ("CEC") rates and Alternative Payment Plan annual rates effective April 1 of each year of this Agreement:

Fiscal Year	Rate Increases
April 1, 2015 – March 31, 2016	0%
April 1, 2016 – March 31, 2017	0%
April 1, 2017 – March 31, 2018	1.0%
April 1, 2018 – March 31, 2019	1.5%

(ii) The rates for ICU and ED will be reviewed and may be adjusted by DHW, with the agreement of DNS.

(iii) The rates in effect as of April 1, 2015 are as outlined in Schedule "A" to this Agreement.

(c) APP Increases

(i) The rate for each Anaesthesia APP and Collaborative GP APP will increase by an annual amount of $10,000 effective upon signing of this Agreement, payable biweekly, and by a further $5,000 effective April 1, 2017. These amounts are for 1.0 FTEs, and will be proportionally reduced for APPs of less than 1.0 FTE.

(ii) The rate for each solo GP APP will increase by an annual amount of $8,000, effective upon signing of this Agreement, payable biweekly. This amount is for 1.0 FTEs, and will be proportionally reduced for APPs of less than 1.0 FTE.

(iii)The Parties agree that all other terms associated with the APP accountability model, continue in effect and may be revised as agreed by the MAMG.

(d) **Fee Schedule Adjustments and New Fees**

(i) The Fee Committee (FC) will review requests for new fees, to amend current fees, and for additions, revisions or clarifications of the Preamble to the MSI Physician's Manual, including any changes to the wording of the MSI Physician's Manual that may be needed as a result.

(ii) The Fee Committee will be governed by the existing terms of reference for the Fee Schedule Advisory Committee established pursuant to the 2008 Master Agreement unless amended by FC.

(iii)Notwithstanding (ii) above, Fee Committee shall have decision-making authority to approve adjustments to the fee schedule for all items where the Committee reaches consensus and for which the Committee has sufficient budget. Items which exceed the Committee's budget or about which the Committee is not able to reach agreement will proceed to the MAMG for decision.

(iv)Notwithstanding (ii) above, either Party may choose to add one additional member to the Committee.

(v) The Parties agree that the Fee Schedule may be adjusted from time to time as approved by the Fee Committee or by the MAMG if referred from Fee Committee.

(vi)The Parties agree that the following funds shall be provided by DHW to the Fee Committee exclusively for new fees, fee adjustments or preamble changes in response to applications:

Fiscal Year	Incremental New Funding
April 1, 2015 – March 31, 2016	$0
April 1, 2016 – March 31, 2017	$815,000
April 1, 2017 – March 31, 2018	$1,000,000
April 1, 2018 – March 31, 2019	$4,500,000

(vii) The Parties agree that the DHW will provide additional funding in the amounts outlined in the following table in order for Fee Committee to establish and/or enhance fees in the following areas.

Fiscal Year	Transition of Programs	Complex Care	Surgical Emergency Premium	Non Face to Face	Methadone
April 1, 2016 – March 31, 2017	$4,270,000	$0	$0	$0	$300,000
April 1, 2017 – March 31, 2018	$10,070,000	$1,000,000	$500,000	$1,500,000	$700,000
April 1, 2018 – March 31, 2019	$0	$0	$0	$1,500,000	$0

(viii) The Parties agree that base funding will not be reduced as a result of unspent fee schedule funding in a year. The Fee Committee shall, by October of each year and periodically thereafter as requested by MAMG, notify the MAMG of any projected funds that may be unused each fiscal year.

(ix)The Parties agree that Fee Committee will review the billing rules for the surgical emergency premium to consider and ensure that the rules governing the premium appropriately support the intent of the premium in circumstances where procedures or consults are done in, or moved to off-hours due to factors beyond the control of the physician.

(x) The Parties agree that, upon application, the Fee Committee will review enhancement of the fees for multiple and bilateral surgical procedures, with any incremental cost to be covered by the funds allocated to Fee Committee as assigned in (vi) of this section.

(xi)The Parties agree that non face to face for physicians will be introduced on a pilot basis. Full parameters and guidelines will be developed by Fee Committee with priority areas that include seniors' care, mental health and chronic care. The program will be reviewed for effectiveness after the end of the second year of the pilot. The Fee Committee will develop, implement, manage, and evaluate interim fees related to the provision of non-face-to-face care, consistent with the following terms:

A. Specialists:

(i) The interim fees will remunerate both physician-to-physician and physician-to-patient telephone interactions that are charted in the patient's record.

(ii) Physician to physician telephone interactions must be accompanied by a written request from a General Practitioner and must be charted by the Specialist.

(iii)The rate for physician to physician interactions will be 25 MSU and for Specialist to patient interactions will be 11.5 MSU.

(iv) Detailed billing rules to be developed by the Fee Committee, which could include for example a restriction that telephone fees are not billable for delivery of normal test results or a restriction that the physician must have seen the patient within a certain amount of time preceding a telephone visit being billed.

B. General Practitioners:

(i) The interim fees will remunerate both physician-to-physician and physician-to-patient telephone interactions that are charted in the patient's record.

(ii) Telephone interactions with patients will be billable only where the patient is 65 years of age or older and/or is suffering from mental illness or chronic disease.

(iii) Physician to physician telephone interactions must be accompanied by a written request from a General Practitioner and must be charted by the General Practitioner.

(iv) The rate will be 11.5 MSU.

(v) Detailed billing rules to be developed by the Fee Committee, which could include for example a restriction that telephone fees are not billable for delivery of normal test results or a restriction that the physician must have seen the patient within a certain amount of time preceding a telephone visit being billed.

C. The interim fees will take effect on April 1, 2017.

D. The Fee Committee will develop an evaluation framework to be shared with the MAMG prior to the new fees taking effect.

E. The Fee Committee will conduct an evaluation of the interim fees 18 months after implementation.

F. The Parties agree that if the MAMG concludes based on the evaluation that the interim fees will be discontinued, then the Parties shall jointly reallocate the actual 2018/19 expenditure on these fees to other non face-to-face patient care initiatives.

(e) Canadian Medical Protective Association ("CMPA") Assistance

(i) DHW agrees to continue to provide funding for CMPA reimbursement in accordance with the following criteria:

a) All Resident Physicians who are funded by the Province will continue to receive full reimbursement of their CMPA premium fees unless in future they receive funding or coverage for this purpose from another source; and

b) All other Physicians will be eligible to receive a reimbursement of 90% of their CMPA premium fees in excess of $1,750.

(ii) Reimbursement will be paid directly by DHW to eligible physicians based on electronic submission of information received from CMPA. DHW will communicate a payment schedule to Physicians and payments will be made on a timely basis and consistent with that schedule.

(f) Continuing Medical Education

DHW will maintain current funding and criteria for the Professional Development Support Programs as outlined in the 2008 Master Agreement for both General Practitioners and Specialists. DHW may randomly withhold annual payments to select physicians pending submission of supporting documentation that CME activities were undertaken in order to substantiate payment.

(g) Electronic Medical Record (EMR)

DHW will provide a one-time Physician-specific EMR Investment Grant of $10,000 (Envelope "A" as outlined in Schedule "I" of the 2008 Master Agreement), for both General Practitioners and Specialists. The eligibility criteria for this Grant in effect at the time of execution of this Agreement shall continue unless changed by MAMG.

(h) Physician Manual Modernization Project (PMMP)

DNS will provide the balance of funds available in the year-end transfer account monitored by the MASG to support the PMMP, with DHW providing all remaining funds to complete the Project (Phase 5). Working with DNS, DHW will develop an implementation plan that includes projected costing.

(i) Continuity of Fees and Programs under the Expired Master Agreement

The Parties agree that certain programs from the expired Master Agreement will be transitioned to fee codes, others will be terminated, and others will continue in their current state, all as outlined in Schedule "B" to this Agreement.

(j) Targeted Project Funding

DHW agrees to provide targeted project funding in accordance with Schedule "C".

(k) Benefits

(i) DHW will fund 65% of all premiums paid to provide health and dental coverage in accordance with the plan in effect upon execution of this Agreement, and 100% of parental leave and professional support program (EAP type) expenses. Any benefits changes which result in increased premiums require approval of DHW to be eligible for continued financial support.

(ii) DHW will reimburse DNS based on monthly invoicing.

(iii) The balance currently held as excess in the DNS Recruitment and Retention Fund under the 2008 Master Agreement will be drawn down to an appropriate reserve as jointly agreed by the Parties after consultation between the Parties' auditors. Any surplus above the agreed reserve will be used to fund the DHW portion of the costs of benefits until the agreed reserve is reached.

(iv) DHW will pay an administration fee of $300,000 per year, which represents 4% of the benefits program value of $7,500,000, payable to DNS monthly, in advance.

(l) **Remit Payments to DNS**

DNS may, at its sole discretion, direct DHW to remit any payments owing to an individual Physician under this Agreement to DNS in the event that the Physician has failed to pay their required DNS dues in a timely manner. Such payments could include any of the payments pursuant to this Article 4. DNS agrees that DHW is in no way liable for the remittance, nor for any challenges, legal or otherwise associated with them. In the event that DHW has engaged a third party to administer payments, DHW agrees to make every reasonable effort to effect any remittance requests through that third party. Any costs associated with these requests shall be the sole responsibility of DNS. DNS may choose to recover those costs from the Physician in question, as determined by DNS.

5. GOVERNANCE

5.1 A Master Agreement Management Group (MAMG) will be established to oversee the implementation and operation of this Agreement.

5.2 The terms of reference and decision making will be as outlined in Schedule "D".

6. ACCESS TO INFORMATION

(a) The Parties agree to share relevant information that is requested by a Party. Relevant historical and predicative data prepared by any Party will be fully shared. In cases where the information is not readily accessible or is not provided on request, the matter may be referred to the MAMG.

(b) DNS will be provided with electronic access to information on a monthly basis regarding Fee-For-Service billings and other payments made by DHW for Insured Medical Services, including the DHW's spreadsheets for Health Service Code, Physicians Payments and Physician Payments by Service Location and, upon request by DNS, electronic access will be provided to other routinely provided DHW information which is in relation to Fee-For-Service billings and other payments made by the DHW including utilization and cost information. The Parties agree that this information will not be in patient identifiable form. DHW agrees to consider all reasonable requests from DNS for changes to the format of this data.

7. CLINICAL ACADEMIC FUNDING PLANS AND ALTERNATIVE PAYMENT PLANS

Payments to Physicians pursuant to Clinical Academic Funding Plans or Alternative Payment Plans are payments for Insured Medical Services that are not included in the Tariff or in the amendments to the Tariff provided for in this Agreement. In the event that a Clinical Academic Funding Plan or Alternative Payment Plan contract is terminated or upon the expiration of any such contract, not renewed or re-negotiated, payment to Physicians for the provision of Insured Medical Services will be made pursuant to the Tariff. Privileges for the same geographic location cannot be withdrawn from or denied to Physicians by DHW or the Health Authorities in these circumstances.

8. AUDITS

DNS agrees that the DHW has the right to conduct audits of Physicians with respect to claims for Insured Medical Services including claims submitted by Physicians pursuant to Clinical Academic Funding Plan and Alternative Payment Plan contracts, within the terms outlined in Schedule "E" to this Agreement. All other contractual performance and compliance issues affecting Clinical Academic Funding Plan and Alternative Payment Plan Physicians shall be resolved pursuant to the terms of those contracts.

9. NOTICE

(a) All notices, requests, demands or other communications (collectively, "Notices") required or permitted to be given by one Party to the other Party pursuant to this Agreement shall be given in writing by personal delivery or by registered mail, postage prepaid, or by facsimile transmission to such other Party as follows:

If to DHW:	Minister of Health and Wellness
With a copy to:	Deputy Minister of Health and Wellness
If to DNS:	President of DNS
With a copy to:	Chief Executive Officer

(b) All Notices shall be deemed to have been received when delivered or transmitted, or, if mailed, Forty Eight (48) hours after 12:01 a.m. on the day following the day of the mailing thereof. If any Notice has been mailed and if regular mail service is interrupted by strikes or other irregularities, such Notice shall be deemed to have been received Forty Eight (48) hours after 12:01 a.m. on the day following the resumption of normal mail service, provided that during the period that regular mail service is interrupted all Notices shall be given by personal delivery or by facsimile transmission.

10. AMENDMENTS

(a) This Agreement may be amended upon Notice at any time by the mutual written consent of the Parties.

(b) No amendment or modification of this Agreement will become effective unless reduced to writing and duly executed by the Parties hereto.

11. CONSEQUENTIAL AMENDMENTS

The Parties agree that the Preamble, the Fee Schedule and any fee codes will be amended where necessary, to implement this Agreement.

12. GOVERNING LAW

This Agreement will be governed by, and construed in accordance with, the laws of the Province of Nova Scotia.

13. HEADINGS

The headings of the Articles of this Agreement have been inserted for reference only and do not define, limit, alter or enlarge the meaning of any provision of this Agreement.

14. ENTIRE AGREEMENT

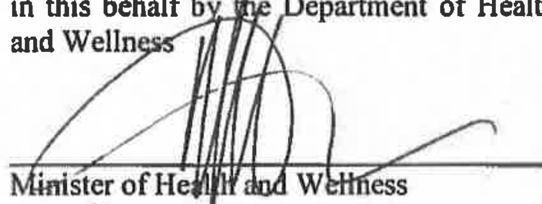
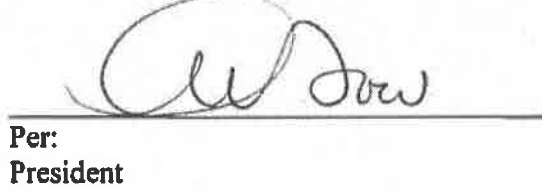
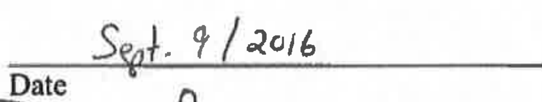
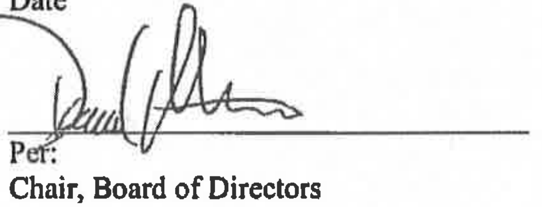
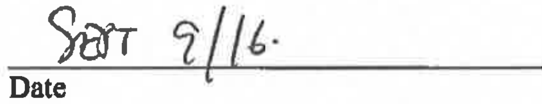
(a) This Agreement and the attached Schedules constitute the whole of the Agreement between the Parties unless duly amended as provided in Article 10.

(b) No representation or statement not expressly contained in this Agreement will be binding upon any Party.

15. BENEFIT AND BINDING

This Agreement shall enure to the benefit of and be binding upon the Parties hereto and their respective successors and assigns.

Dated at Halifax, in the Halifax Regional Municipality, Province of Nova Scotia, on this 9th day of September, 2016.

SIGNED, SEALED AND DELIVERED in the presence of	)	**HER MAJESTY THE QUEEN** in right of the Province of Nova Scotia as represented in this behalf by the Department of Health and Wellness
Witness	)	 Minister of Health and Wellness
	)	Date
	)	**DOCTORS NOVA SCOTIA**
Witness	)	 Per: President
	)	 Date
Witness	)	 Per: Chair, Board of Directors
	)	 Date

SCHEDULE "A"

RATES EFFECTIVE APRIL 1, 2015

A. Sessional hourly rates: $145.20 for General Practitioners and $169.40 for Specialists.

B. ICU minimum daily income guarantees: as outlined in the Regional Hospital Intensive Care Unit and Comprehensive Care Alternate Payment Plan Options and Operating Guidelines, signed by the Parties on December 16, 2008.

C. Psychiatry hourly rates: $149.90 for certified and $110.55 for non-certified.

D. Emergency hourly rates: $192.00 for regional sites, $167.04 for other hybrid funding sites, $147.62 for Level 3 sites and $73.81 for Level 4 sites.

E. GP Alternative Payment Plan annual rate: $235,667.

F. Palliative Care/Geriatrics Alternative Payment Plan annual rates: $235,667 for General Practitioners with no additional training, $242,093 for General Practitioners with post-graduate certification, and $261,541 for certified Specialists.

G. Neonatology Alternative Payment Plan annual rate: $283,780.

H. Obstetrics/Gynecology Alternative Payment Plan annual rate: $331,416.

I. Pediatrics Alternative Payment Plan annual rate: $286,082.

J. Anesthesia Alternative Payment Plan annual rates: $265,299 for Category 1 and $250,041 for Category 2.

K. CAPP rates: shall be the rates as approved and in effect as of April 1, 2015.

L. CEC rates: shall be the direct funding provided by DHW for each CEC as of April 1, 2015.

SCHEDULE "B"

TRANSITION, TERMINATION AND CONTINUATION OF 2008 MASTER AGREEMENT PROGRAMS

I. PROGRAMS TRANSITIONING TO FEE-BASED INITIATIVES

(a) The funding for the following programs will transition to fee-based initiatives as outlined in Article 4:

(i) Comprehensive Care Incentive Program (CCIP)

(ii) Collaborative Practice Incentive Program

(iii) Electronic Medical Records Envelopes B and C

(iv) Unattached and Orphan Patients Program (collectively, the "Transitioning Programs")

(b) The Fee Committee will be provided with a budget as outlined in Article 4.1(d)(vi) and the Committee will decide on appropriate fee codes and fee values to support physicians in providing care. First priority areas will be participating in comprehensive care, collaborative practice, utilizing electronic medical records and addressing the issue of unattached and orphan patients.

(c) For purposes of the CCIP, the Fee Committee will set fees that ensure the $6 million CCIP budget is reallocated in support of primary care. The Parties have completed an initial assessment for home visits, nursing home visits, inpatient care, maternity and newborn care, and visits with children under the age of two. Additional fees to support comprehensive care will be determined by the Fee Committee, with the following areas as priority: tray fees for certain in-office procedures, care plan oversight for care of patients in nursing homes, travel fees for home and nursing home visits, visits with children at five years old, and geriatrics visits.

(d) The Transitioning Programs shall end when new fees are approved by the Fee Committee or MAMG (on referral from Fee Committee) and put in effect by DHW.

II. PROGRAMS BEING TERMINATED

(e) DHW will terminate the Community Remote Practice On-Call program on a staged basis. Effective upon execution of this Agreement, the pro-rated annual amount for General Practitioners currently eligible for this program will be reduced to $20,000. Effective April 1, 2017, the annual amount will be reduced to $10,000 and effective April 1, 2018 the bi-weekly payments will be terminated.

(f) DHW and the Health Authorities will develop a new Community On-Call Program, subject to DNS approval of the rates. Funding for any such Program will be secured by DHW outside the parameters of this Agreement.

III. PROGRAMS CONTINUING IN MODIFIED FORM

Rural Specialist Retention

(g) The Rural Specialist Incentive Program will continue in its current form. The MAMG will review the Program to better incent recruitment in addition to retention. Program modifications are effective no earlier than April 1, 2017.

Complex Care Visit and Chronic Disease Management Fees

(h) The Chronic Disease Management and Complex Care Visit Fees will continue in their current form until revised by the Fee Committee. The Fee Committee will review and revise the fees to ensure they are more reflective of the level of service required to manage chronic/complex illness and available for the care provided to a greater portion of the chronically ill patient population, and will utilize the additional $1 million investment pursuant to article 4.1(d)(vii) to enhance or add new fees to support complex and chronic care.

Facility On-Call

(i) The Facility On-Call program rates will continue in its current form. All approved on-call rotas will be reviewed by the Health Authority to ensure they align with patient care and service coverage requirements. All required rotas continue to be funded (unless determined to no longer be required) and other eligible rotas are able to be funded through the program.

IV. PROGRAMS CONTINUING IN CURRENT FORM

(j) All other fee-based and program funding in effect on the date of execution of this Agreement shall continue with the same terms and conditions as those in effect on the date of execution, unless the Parties agree otherwise. This includes but is not limited to:

- GP Surgical Assist Program
- Nova Scotia Provincial Locum Program
- Emergency Department Services and Compensation
- Regional Hospital Intensive Care Unit Payment Plan
- Evening and Weekend GP Office Visit Incentive
- Continuing Care

SCHEDULE "C"

TARGETED PROJECT FUNDING

- **Goal: Targeted funding must be accountable to Nova Scotians and support quality patient care and system priorities**

Parameters for all Project Funding

- Project work (including deliverables) supporting the three areas identified below and approved by MAMG
- Project work will align with DNS fiscal year (Sept-Aug)
- Quarterly reports to MAMG summarizing work done and time spent.
- Maximum amount allocated for each fiscal year, to be paid to DNS on a quarterly basis.
- Maximum amounts identified below are fixed overall but may be adjusted between priority areas as agreed by MAMG.
- DNS agrees to conduct a reconciliation at each year-end to ensure time spent equates to time paid. Reconciliation to be based on time spent and agreed upon hourly amount
    - Agreed upon hourly amount for physicians is based on $150.00 per hour
    - Agreed upon hourly amount for staff is $70 per hour (time to be reported based on half-days)

Project Funding:

1. Fee Schedule

Purpose: Support to FSC and fee schedule related items

Amount: Maximum annual amount ($330,000)

Project work to include:

- Research required to support FSC applications (Typically a medical professional)
- General Support to FSC
    - Track all applications to FSC
    - Responsible for timely communication to applicants (at the direction of FSC)
- Support for the Application Process, including but not limited to:
    - Make applications available to physicians
    - Ensure communication to physicians on a regular basis on the application process
    - Liaison between FSC and physician to ensure applications are complete
- Work between DHW/MSI medical consultants on billing issues
    - Mediating potential disputes between physicians and MSI/DHW
    - Working with DHW/MSI to address fee related issues
- Other work as agreed

2. Clinical Practice Support

Purpose: Projects that support physicians attempting to transition their practices in alignment with health system change and priorities.

Amount: Maximum annual amount ($500,000)

Project work to include but not be limited to:

- Support for physicians transitioning to an EMR. Includes expectation that staff will need to visit physicians' offices to support the transition.
- Support for physicians to ensure maximum use of EMR.
- Support for physicians to eliminate office Fax machines
- Other areas as agreed to

Some of this project work will need to take place in physician's offices. Others will require a liaison function as between DHW, the Health Authorities, DNS and physicians to support physicians in transitioning their practices in ways that align with health system priorities.

3. Physician Initiatives

Purpose: Joint initiatives between DNS and DHW that support physicians and residents

Amount: Maximum annual amount $625,000

Initiatives to include:

- CME (effective April 1, 2017 transition this funding to Labour and Advanced Education)
- Bursary program
- Retirement and succession planning
- Support through MSI for billing education sessions
- Medical student engagement
- Physician leadership
- Other initiatives as directed by the MAMG

SCHEDULE "D"

GOVERNANCE

Principles:

- Governance structure designed to foster and support an ongoing collaborative relationship between DNS, DHW and the NSHA/IWK
- Agile and flexible structure with ability to adjust as the system evolves
- Ensure accountability and transparency in contract management

Committee:

Master Agreement Management Group (MAMG)

- Mandate:
  - To oversee the implementation and operation of the Master Agreement
  - To discuss any operational issues arising from the Master Agreement
  - To establish working groups and engage contractors and/or consultants as required to investigate issues of importance to the ongoing implementation and oversight of the Master Agreement
    - Determine specific projects to be funded in a year when DHW identifies funds available from under-utilization trends in fee schedule
  - To receive reports on Master Agreement initiatives, including:
    - DHW to provide quarterly financials on the Agreement
    - Quarterly reports from DNS on work done and invoiced from Project Funding initiatives
    - DHW/NSHA to provide reports on the performance of programs (uptake; outcomes; etc.)
  - To oversee an evaluation of the non face-to-face patient care program and make decisions arising out of the results of that evaluation
  - To make decisions on matters arising during the life of the Agreement. Examples we can anticipate:
    - Approval of the community on-call rate once the program is designed
    - Decisions on how to allocate funds that may become available during the life of the agreement from CMPA in the event of a reduction in CMPA fees, and the non face-to-face budget in the event that the program evaluation does not support its continuation
    - Issues that Fee Committee may refer to MAMG

- Decisions of the MAMG shall be:

  (i) In the first instance by consensus.

  (ii) If consensus is not reached on an issue, then by majority.

  (iii) In the event that a majority decision cannot be reached, then a ninth member will, at the request of either Party, be appointed by the co-chairs for resolution of the issue.

  (iv) The ninth member will chair those portions of the MAMG meeting(s) which involve consideration of the unresolved issue, will decide how best to conduct the meeting(s) and to resolve the issue, and will have all powers granted pursuant to the *Commercial Arbitration Act*. This is not

intended to be a formal arbitration. There shall be no legal counsel and no calling of evidence. The rules of natural justice do not necessarily apply, except in the discretion of the ninth member.

(v) The decision of the MAMG reached through this process shall be final and binding on all Parties.

In the event that the Parties have a dispute with respect to the interpretation or application of an MAMG decision, or that either Party has a dispute with respect to the conduct of the other Party regarding the interpretation, application or administration of this Agreement, the dispute shall be resolved pursuant to this MAMG decision-making process.

- Standing Committees:
  - MAMG may agree to establish standing committees as necessary.
  - APP Working Group to continue. Recognizing this is a priority area the mandate of this group will be determined by MAMG.

- Composition and frequency of MAMG meetings:
  - To be composed of 4 DNS representatives and 4 DHW representatives.
  - To meet at least quarterly.
  - DHW to continue to prepare agendas and meeting materials in consultation with DNS.

SCHEDULE "E"

Claims Monitoring and Resolution Mechanism

Preamble

In May 2013, the DHW and DNS jointly commissioned Mr. John Carter, FCA to review the claims monitoring and resolution mechanisms that were in place in Nova Scotia at that time. The resulting report, *The Physician Audit and Appeal in Nova Scotia*, recommended a number of improvements based on best practices across the country to ensure appropriate accountability, while at the same time reducing claims payment wait time in some areas.

An implementation team was struck to execute the report's recommendations, and was comprised of representatives from DNS, the DHW and Medavie Blue Cross (the claims administrator for Medical Services Insurance or MSI), as well as Mr. Carter. This collaborative process has resulted in a new appeal process (Schedule E) that will guide future audit and pre-payment assessment appeals.

All parties agree that it is the physician's responsibility to ensure claims are appropriate and consistent with the MSI Physician's Manual and clarifications articulated in the Physicians' Bulletins and that they meet required minimum standards for billing purposes. To assist the physicians and in the spirit of ongoing collaboration DNS and DHW acknowledge that education of physicians about appropriate billing is a joint responsibility and that together, all parties will continue to work on mechanisms to educate physicians.

1. For the purposes of this Schedule "E":

    a) **Audit Period** is limited to the twenty-four (24) months prior to the commencement of the audit, unless otherwise extended pursuant to Article 20;

    b) **Claims** means both fee for service and shadow service claims;

    c) **Days** means business days;

    d) **Implementation Date** means thirty (30) calendar days after Schedule "E" is fully executed by both DNS and DHW;

    e) **MSI** means Medical Services Insurance as administered by Medavie Blue Cross and any successor organization operating on behalf of the Province of Nova Scotia in respect of the payment to physicians for insured medical services;

    f) **Monitoring** includes both pre-payment assessment of Claims and post payment audit of Claims;

    g) **Party** means DHW or the physician;

    h) **Post payment audit of Claims** includes any automated and/or manual systems and process in place to review Claims submitted by physicians after a Claim has been paid; and

i) **Pre-payment assessment of Claims** includes any automated (rules in the billing system) and/or manual systems and processes in place to review Claims submitted by physicians prior to payment.

2. DHW, through MSI, shall conduct Monitoring of Claims intended to determine whether:

   a) the service was an insured service in Nova Scotia;

   b) the service was performed;

   c) the service was medically necessary;

   d) the service was correctly represented in the Claim for payment; and

   e) the service meets the requirements set out in:

      i. the Preamble of the MSI Physician's Manual, and

      ii. any relevant clarification provided to physicians in the MSI Physicians Bulletin

3. DHW, through MSI, shall ensure that the Claims monitoring and resolution process as outlined herein is followed.

Pre-Payment Assessment

4. If a physician's Claims are adjusted or rejected as the result of a Pre-Payment Assessment, the physician will be notified electronically by MSI through the adjudication response (the "MSI Result").

5. The physician is deemed to receive the MSI Result five (5) days after the day the MSI Result is sent.

6. If Pre-Payment Assessment results in adjustment or rejection of a Claim due to rules that are in the billing system, it cannot be disputed by an individual physician. In this circumstance, DNS has the authority, as the sole bargaining agent for physicians in Nova Scotia, to raise the issue with the Master Agreement Management Group, if DNS in its sole discretion determines that the subject matter requires further consideration.

7. If Pre-Payment Assessment results in adjustment or rejection of a Claim for any other reason (including but not limited to Claims assessed as part of the pre-payment assessment of multiple Claims [same patient, same day, same provider] or Claims assessed as part of a random pre-payment assessment process), the physician can dispute the adjustment and/or rejection as provided herein.

8. In order to dispute a MSI Result, the physician must, within ten (10) days after receipt of the MSI Result, contact MSI in writing to initiate the Request for Pre-payment Assessment Review. If the physician fails to contact MSI within that time, he/she is deemed to agree with the MSI Result and forfeits further rights to Facilitated Resolution or Arbitration.

9. Once a Pre-Payment Assessment Review is initiated this will be considered by both the DHW Medical Consultant and the DNS Medical Consultant within fifteen (15) days of receipt of the Request for Pre-Payment Assessment Review.

10. If both the DHW and DNS Medical Consultants determine that the dispute involves a policy decision the MSI Result cannot be disputed by an individual physician and that physician will be notified by DHW, with a copy to DNS. A policy decision includes but is not limited to items specifically negotiated by DNS and DHW. In this circumstance, DNS has the authority, as the sole bargaining agent for physicians in Nova Scotia, to raise the issue with the Master Agreement Management Group, if DNS in its sole discretion determines that the subject matter requires further consideration. The physician will have no further access to the Schedule "E" process for the Pre-Payment Assessment, and no further right of appeal.

11. If one or both of the DHW and DNS Medical Consultants determines that the dispute does not involve a policy decision then the pre-payment assessment will move directly to Facilitated Resolution, commencing at Clause 31.

12. If both the DHW and DNS Medical Consultants agree that the Claims being submitted by a physician indicate a pattern of deliberate non-compliance with the MSI Physician's Manual and/or MSI Bulletins, that physician will have no further access to the Schedule "E" process for the Pre-Payment Assessment, and no further right of appeal on that matter.

Post-Payment Audit

13. A physician may be identified for post-payment audit (the "Audit") in a variety of ways, including but not limited to:

    - Service Verification Letters;
    - Case Mix Grouping - Peer Profiling;
    - Referral;
    - Periodic Random Selection;
    - Use of New Fee Codes;
    - Specific Fee Codes identified for audit.

14. An Audit may occur by way of periodic review of MSI data (periodic review) and/or an on-site visit.

Periodic Review

15. A physician will not be notified in advance of an audit conducted by way of periodic review of MSI data.

16. The results of the Audit will be provided to the physician in writing (the "Audit Result") where, in the auditor's opinion, the periodic review showed the physician's billing to be inappropriate.

On-Site Audits

17. Any physician identified for an on-site Audit will be notified in writing that an Audit will occur and which fee codes will be included in the Audit. The Audit will be scheduled at a mutually agreeable time. The auditor may require inspection of any books, accounts, documents, reports, invoices and patient records in any form, including electronic that are maintained by or on behalf of the physician (the "Records") to clarify or verify services for which Claims have been submitted.

18. The results of the Audit will be provided to the physician in writing (the "Audit Result").

Audit Scope

19. The auditor may, acting objectively and with reasonable notice, extend an audit of a physician's practice to cover fee codes that were not originally selected if the audit results suggest potential for additional incorrect billings. The reasons for extending the fee codes audited must be provided to the physician with the notice of the extension and cannot be challenged as a part of the Audit and Appeal process.

20. The Audit Period may be extended in exceptional circumstances.

Notification of Audit Results

21. For the purposes of Clauses 16 and 18, notice of the Audit results will include:

    a) a detailed summary of each Claim deemed to be inappropriate with explanatory comments as to the nature of the deficiency;

    b) the financial implications of the Audit; and

    c) details on what steps may be taken to resolve the matter, which will include a link to an electronic copy of this Schedule E.

22. The physician is deemed to receive the Audit Result five (5) days after the day it is sent by regular post.

23. A cover letter that identifies the physician, and states that a notice of the Audit Result has been issued, will be copied to DNS; the notice itself, as well as any additional details, will be sent to the physician alone.

Audit Review

24. Where the physician disagrees with the Audit Result, the physician will, within twenty (20) days of receipt of the findings, contact MSI in writing to initiate the Audit Review (Notice of Audit Review). The Notice will include the basis for the disagreement and provide documentation, including all relevant clinical documentation, to support that position. If

the physician fails to provide the Notice to MSI within that time, s/he is deemed to agree with the Audit Result and forfeits further rights to Audit Review, Facilitated Resolution, or Arbitration. If deemed to agree with the Audit Result then any associated recovery shall be made from future payments to the physician. The purpose of the Audit Review is to ensure that MSI has all information/documentation relevant to the Audit.

25. MSI will review all information and documentation provided as part of the Notice of Audit Review. After the Review, the MSI Medical Consultant may do one of the following:

    a) In order to ensure an efficient and effective Audit Review process, if, in the sole discretion of the MSI Medical Consultant, the Notice provided by the physician does not provide any new information that may change the Audit Result, the MSI Medical Consultant will issue a Notice of Determination and the matter may be referred directly to Facilitated Resolution (without an Audit Review meeting between the MSI Medical Consultant and the physician).

    b) Request a meeting with the physician, either by telephone or in person, to facilitate the documentation review process; such meeting to be scheduled within fifteen (15) days of receipt of the Notice of Audit Review.

26. Upon review of all additional information/documentation provided to MSI by the physician, MSI will issue a Notice of Determination.

27. The Notice of Determination shall include:

    - a statement of the findings of the Audit, including any adjustments made as a result of the Audit Review;
    - detail of all outstanding issues that have not been resolved; and
    - a form that may be used by the physician to object to the Notice of Determination.

28. A cover letter that identifies the physician, and states that a Notice of Determination has been issued, will be copied to DNS; the Notice itself, as well as any additional details, will be sent to the physician alone.

29. If the physician disagrees with the Notice of Determination, the physician may, by notice in writing, within twenty (20) days from the date he/she receives the Notice of Determination, submit an objection in writing to MSI (the "Notice of Dispute"). In the Notice of Dispute, the physician may only make representations related to matters referred to in the Notice of Determination, or which are related directly thereto. If the physician fails to contact MSI within that time, he/she is deemed to agree with the Audit Result and forfeits further rights to Facilitated Resolution or Arbitration. Any associated recovery shall be made from future payments to the physician.

30. The physician is deemed to receive the Notice of Determination five (5) days after the day it is sent by regular post.

Facilitated Resolution

31. When MSI receives a Notice of Dispute, or where either the DHW Medical Consultant or the DNS Medical Consultant determines that a pre-payment assessment dispute does not

involve a policy decision per Clause 11, the Facilitated Resolution stage will begin. MSI will notify both the DHW and DNS Medical Consultants.

32. DHW and DNS will agree upon a list of Facilitators in a separate document. The Facilitator will be chosen from that list by starting at the top and moving down until a non-conflicted Facilitator is located that is available to begin the Facilitated Resolution within sixty (60) days. In the event none of the Facilitators are available within sixty (60) days' time, the next available non-conflicted Facilitator will be chosen. For each subsequent Facilitated Resolution, the search for available Facilitators will commence at the point on the list that is immediately after the Facilitator most recently chosen to participate.

33. The Facilitated Resolution will proceed on a "without prejudice" basis and will commence on a date agreed upon by DNS and DHW that is no later than sixty (60) days after appointment of a Facilitator; if agreement on a Facilitated Resolution date is not reached, the Facilitated Resolution will commence on the first business day following expiry of the sixty (60) days.

34. The Facilitated Resolution will proceed in accordance with Schedule C of the *Commercial Arbitration Act*, S.N.S. 1999, c.5, (CAA) with the exception of CAA Clauses 2, 15 and 16, and with the Facilitator having the same duties and powers as a CAA mediator.

35. The Facilitated Resolution will involve only the DHW Medical Consultant, the DNS Medical Consultant, MSI audit personnel, the physician, and the Facilitator. For the sake of certainty:

    - legal representatives will not attend the Facilitated Resolution;
    - agreement may only be reached with consensus between the DHW Medical Consultant and the physician;
    - if agreement is reached, the Facilitator will document the terms of the agreement (the Agreement) and the DHW Medical Consultant and the physician will sign the Agreement, at which time the Agreement will become binding on both Parties;
    - if agreement is not reached, the physician has thirty (30) days to provide notice of intent to proceed to Arbitration as outlined herein. If no notice is provided, the physician is deemed to agree with the Audit Results and forfeits further rights to Arbitration.

36. Each Party is responsible for its own legal costs. The Parties will each bear half of all other expenses related to the Facilitated Resolution, unless DHW and DNS agree on an alternative arrangement.

37. If either DHW or the physician do not participate in the Facilitated Resolution, the non-participating party is deemed to have forfeited its claim against the other and the matter is concluded, excepting however where both the DHW and the physician, acting reasonably, agree to reschedule the Facilitated Resolution, it may be rescheduled to a date that is no later than thirty (30) days after the originally scheduled date.

38. Upon receipt of notice to proceed to Arbitration, the dispute will be finally determined by Arbitration presided over by a Resolution Panel (the "Panel"). The Arbitration will proceed in accordance with the *Commercial Arbitration Act*, S.N.S. 1999, c.5, (CAA) except as specifically altered herein. The parties agree that only matters contained in the Notice of Determination which are contested in the Notice of Dispute will be subject to Arbitration.

39. The Panel will be comprised of three individuals, one from each of the Lawyer, Non-Physician, and Physician Categories, as set out in a document agreed upon by both DNS and DHW, and once constituted, shall be an arbitrator under the CAA. All three individuals will be chosen to form the Panel by starting at the top of each Category's list and moving down until a non-conflicted Member from each Category is located that is available to participate in the Arbitration within sixty (60) days' time. In the event none of the Members in a particular Category are available within sixty (60) days' time, the next available non-conflicted Member in that Category will be chosen. For each subsequent Panel, the search for available Members will commence at the point on each Category list that is immediately after the Member most recently chosen to participate on a Panel. The Panel Member chosen from the Lawyer Category will serve as Chair of the Panel.

40. For the Lawyer Category, there will be a roster of no less than three lawyers jointly appointed by DNS and DHW. Each lawyer will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

41. For the Non-Physician Category, there will be a roster of no less than three non-physicians jointly appointed by DNS and DHW. Each non-physician will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

42. For the Physician Category, there will be a roster of no less than ten physicians jointly appointed by DNS and DHW. The physicians will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

43. The physician is entitled to have legal counsel present at the Arbitration. If the physician elects to do so, DHW may also have legal counsel present.

44. The Panel will determine the dispute based on the Physician's Manual, including the Preamble thereto and MSI Bulletins. Relevant written correspondence/documents between MSI and the physician may be considered. Only that version of the Manual and those Bulletins that were in effect at the time the services in dispute were provided will be considered.

45. The Panel will determine the dispute by majority vote.

46. The decision of the Resolution Panel shall be final and binding on the physician and DHW. The Chair will provide a written decision, signed by all members of the Panel, within ten (10) days of the conclusion of the Arbitration.

47. Each Party is responsible for its own legal costs. The Parties will each bear half of all other expenses related to the Arbitration, unless DHW and DNS agree on an alternative arrangement. Notwithstanding the above, the Panel may apportion non-legal expenses as it sees fit.

48. Any amounts owing to either the physician or DHW as a result of the decision of the Panel will be due and payable on the date of the Decision, and will bear interest from that day at the prime rate as calculated by the Minister of Finance from time to time, based upon the variable reference rates of interest declared by the five largest Canadian financial institutions or their successors as their rates for Canadian dollar consumer loans, plus an additional 2%. The prime rate is calculated by ignoring both the highest and the lowest of those five rates and taking the average of the remaining three rates.

49. DHW and DNS agree to review the process one (1) year after its implementation, and agree that, unless the Parties agree otherwise, Schedule "E" will terminate upon termination of the Physician Services Master Agreement.

50. Without limiting the generality of the foregoing, if after one (1) year the Facilitated Resolution phase does not successfully resolve 65% of the files it receives, specifically excluding the files which reach Facilitation by way of the Transition Process, the Facilitated Resolution phase will be removed from Schedule "E", unless both DHW and DNS agree otherwise.

51. Any clause in this Schedule may be altered or waived with the agreement of the DHW Medical Consultant and the DNS Medical Consultant.

Transition Provisions

52. With the exception of any Arbitrations that are already scheduled as of the Implementation Date of the revised Schedule E, any portion of the claims monitoring process as defined herein that remains outstanding at the Implementation Date shall be governed by the revised Schedule E.

53. With the exception of any Arbitrations that are already scheduled as of the Implementation Date, each physician for whom any portion of the claims monitoring process is ongoing will be notified fifteen (15) days in advance of the Implementation Date.

54. Within twenty (20) days of the Implementation Date, each physician must communicate a request to proceed to the next step in the claims monitoring process, otherwise any outstanding Audit or Pre-payment assessment will be confirmed.

    a) For greater certainty:

        i. a physician who has received and disagrees with an Audit Result shall submit to MSI a Notice of Audit Review to initiate Audit Review as outlined herein;

        ii. a physician who has received and disagrees with a Notice of Determination shall submit a Notice of Dispute in writing to MSI, and Facilitated Resolution shall proceed as outlined herein;

iii. a physician who has submitted a Notice of Dispute but has not yet had Arbitration scheduled shall proceed with Facilitated Resolution as outlined herein.

55. Any dispute that ceases to follow the processes set out in this Schedule E, or the initiation of any insolvency steps by the Physician, will result in the commencement of collection procedures as outlined herein.

56. DNS and DHW agree that, pursuant to s. 7 of the Doctors Nova Scotia Act, this Schedule E is an agreement which DNS may enter into that binds its members.

57. Physicians are only permitted to challenge pre-payment assessment of claims and/or post-payment audit of claims through the processes outlined in this Schedule.

58. The results of any arbitration, facilitated resolution or decision pursuant to clauses 6, 10, 12, 19, 20, and 25(a) are final and conclusive, and are not open to question or review by a court or other body on any grounds, including by way of judicial review.